		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045753

Facility Name: Litchfield HealthCare Center

Address: 1285 East Union Avenue (Number) Litchfield (City) 62056 (Zip Code)

County: Montgomery

Telephone Number: (217) 324-3996 **Fax #** (217) 324-6032

IDPA ID Number: 38-2795206

Date of Initial License for Current Owners: 02/19/1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Chris Henderson **Telephone Number:** (832) 467-6307

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Greg Williams
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,502	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,303	308	3,879	6,490	8
9	SNF/PED					9
10	ICF	18,291	6,529	219	25,039	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,594	6,837	4,098	31,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.04%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/ 01 / 1992

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,879

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	151,219	13,451	10,154	174,824		174,824		174,824			1
2	Food Purchase		136,821		136,821	(3,710)	133,111		133,111			2
3	Housekeeping	85,076	8,473		93,549		93,549		93,549			3
4	Laundry	65,301	12,455		77,756		77,756		77,756			4
5	Heat and Other Utilities			119,762	119,762		119,762	152	119,914			5
6	Maintenance	22,157	36,414	8,401	66,972		66,972	83	67,055			6
7	Other (specify):* Waste/Garbage See pg 3.1			8,699	8,699		8,699		8,699			7
8	**TOTAL General Services**	323,753	207,614	147,016	678,383	(3,710)	674,673	235	674,908			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,262,825	64,609	14,955	1,342,389		1,342,389	19,477	1,361,866			10
10a	Therapy	169,616	16,112	18,291	204,019		204,019		204,019			10a
11	Activities	36,391	1,761	2,338	40,490		40,490		40,490			11
12	Social Services	13,651		2,668	16,319		16,319		16,319			12
13	Nurse Aide Training											13
14	Program Transportation			25	25	(25)						14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,482,483	82,482	47,277	1,612,242	(25)	1,612,217	19,477	1,631,694			16
	C. General Administration											
17	Administrative	69,199			69,199		69,199		69,199			17
18	Directors Fees											18
19	Professional Services			486	486		486		486			19
20	Dues, Fees, Subscriptions & Promotions			17,803	17,803		17,803	(4,031)	13,772			20
21	Clerical & General Office Expenses	109,283	5,515	234,200	348,998		348,998	(55,064)	293,934			21
22	Employee Benefits & Payroll Taxes			397,896	397,896	3,710	401,606	(3,710)	397,896			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,635	13,635		13,635	9,999	23,634			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			105,294	105,294		105,294	(31,961)	73,333			26
27	Other (specify):*											27
28	**TOTAL General Administration**	178,482	5,515	769,314	953,311	3,710	957,021	(84,767)	872,254			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,984,718	295,611	963,607	3,243,936	(25)	3,243,911	(65,055)	3,178,856			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	5,969
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	2,730
Garbage Service <> Default <> Physical Plant	0
	8,699

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

Facility Name & ID Number Litchfield HealthCare Center # 0037689 Ending: 12/31/2004

Meals - adjustment

31,529	Days (Total Patient days)
3	Mult (3 meals a day)
94587	Sub total
2636	meals to employess (reported by facility)
97223	Add Sub
136,821	Divide -Pg 3, line 2, column 2
1.41	Cost per day
1.41	Cost per day
2636	mult - meal to employees
3710	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

136,821	Total Food Cost (page 3,Line 2, col 3)
0.01	Mult
1368.21	Sub total
21.68%	Mult (Pvt pay div by total census)
297	
	for page 5A,
148.35	= adjust for nonallowable sale tax

Facility Name & ID Number Litchfield HealthCare Center #0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,470	26,470		26,470	40,561	67,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(122)	(122)		(122)	122				32
33	Real Estate Taxes			69,912	69,912		69,912	(4,119)	65,793			33
34	Rent-Facility & Grounds			150,000	150,000		150,000	6,636	156,636			34
35	Rent-Equipment & Vehicles			9,272	9,272		9,272	1,261	10,533			35
36	Other (specify):* Home Office							10,153	10,153			36
37	**TOTAL Ownership**			255,532	255,532		255,532	54,614	310,146			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					25	25	(25)				38
39	Ancillary Service Centers		55,900	11	55,911		55,911	25,359	81,270			39
40	Barber and Beauty Shops			10,038	10,038		10,038	(10,038)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,528	67,528		67,528		67,528			42
43	Other (specify):* See Sch pg 4.1			20,043	20,043		20,043		20,043			43
44	**TOTAL Special Cost Centers**		55,900	97,620	153,520	25	153,545	15,296	168,841			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,984,718	351,511	1,316,759	3,652,988		3,652,988	4,855	3,657,843			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	15,505
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	4,538
	20,043

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,710)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	122	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(86)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	9,714	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(246,070)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (240,030)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	244,885		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 244,885		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 4,855		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 25	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 25		47

STATE OF ILLINOIS

Litchfield HealthCare Center

ID# 0045753

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Tax	$ (148)	21	1
2	Depreciation Reconciliation	40,561	30	2
3	Property Tax Adjustment to Actual	(4,659)	33	3
4	Rental Receipts	(100)	21	4
5	Civic Dues	(100)	20	5
6	Penalities and Fines	(86)	21	6
7	Vending Receipts	(1,451)	21	7
8	Marketing Wages	(1,815)	21	8
9	Marketing Bonus	2,982	21	9
10	Marketing Holiday	(147)	21	10
11	Marketing Vacation	(147)	21	11
12	Entertainment	(2)	24	12
13	Legal Structure Management	(234,200)	21	13
14	Transportation	(25)	38	14
15	Barber & Beauty	(10,038)	40	15
16	Non Allowable Advertising Coat	(4,734)	20	16
17	Professional Liability Insurance	(31,961)	26	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(246,070)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	152	0	0	0	0	0	0	0	0	0	152	5
6	Maintenance	0	83	0	0	0	0	0	0	0	0	0	83	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	235	0	0	0	0	0	0	0	0	0	235	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	19,477	0	0	0	0	0	0	0	0	0	19,477	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	19,477	0	0	0	0	0	0	0	0	0	19,477	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,834)	803	0	0	0	0	0	0	0	0	0	(4,031)	20
21	Clerical & General Office Expenses	(225,484)	170,420	0	0	0	0	0	0	0	0	0	(55,064)	21
22	Employee Benefits & Payroll Taxes	(3,710)	0	0	0	0	0	0	0	0	0	0	(3,710)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2)	10,001	0	0	0	0	0	0	0	0	0	9,999	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(31,961)	0	0	0	0	0	0	0	0	0	0	(31,961)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(265,991)	181,224	0	0	0	0	0	0	0	0	0	(84,767)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(265,991)	200,936	0	0	0	0	0	0	0	0	0	(65,055)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Litchfield HealthCare Center # 0045753 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	40,561	0	0	0	0	0	0	0	0	0	0	40,561	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	122	0	0	0	0	0	0	0	0	0	0	122	32
33	Real Estate Taxes	(4,659)	540	0	0	0	0	0	0	0	0	0	(4,119)	33
34	Rent-Facility & Grounds	0	6,636	0	0	0	0	0	0	0	0	0	6,636	34
35	Rent-Equipment & Vehicles	0	1,261	0	0	0	0	0	0	0	0	0	1,261	35
36	Other (specify):*	0	10,153	0	0	0	0	0	0	0	0	0	10,153	36
37	**TOTAL Ownership**	36,024	18,590	0	0	0	0	0	0	0	0	0	54,614	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(25)	0	0	0	0	0	0	0	0	0	0	(25)	38
39	Ancillary Service Centers	0	25,359	0	0	0	0	0	0	0	0	0	25,359	39
40	Barber and Beauty Shops	(10,038)	0	0	0	0	0	0	0	0	0	0	(10,038)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(10,063)	25,359	0	0	0	0	0	0	0	0	0	15,296	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(240,030)	244,885	0	0	0	0	0	0	0	0	0	4,855	45

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attachment page 6.1		Mariner Health Care	Alanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 152	$ 152	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	83	83	2
3	V	39	Professional Services		Mariner Health Care	100.00%	25,359	25,359	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Health Care	100.00%	803	803	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	19,477	19,477	5
6	V	21	Clerical & General Office Exp		Mariner Health Care	100.00%	170,420	170,420	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	10,001	10,001	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%			8
9	V	36	Depreciation		Mariner Health Care	100.00%	10,153	10,153	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	540	540	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	1,261	1,261	11
12	V	34	Leasse Expense		Mariner Health Care	100.00%	6,636	6,636	12
13	V	26	Property Insurance		Mariner Health Care	100.00%			13
14	Total			$			$ 244,885	$ * 244,885	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Related Illinois Nursing Homes as of 12/31/2004

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HealthCare Center	0037689
	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities		1		$ 152	$	1	$ 152	1
2	6	Repair & Maintenance		1		83		1	83	2
3	39	Professional Services		1		25,359		1	25,359	3
4	20	Fees, Subscriptions, Promotions		1		803		1	803	4
5	10	Nursing & Medical Records		1		19,477		1	19,477	5
6	21	Clerical & General Office Exp		1		170,420		1	170,420	6
7	24	Travel & Seminar		1		10,001		1	10,001	7
8	26	Insurance Premium		1				1	0	8
9	36	Depreciation		1		10,153		1	10,153	9
10	33	Taxes - Property		1		540		1	540	10
11	35	Rental & Leasing		1		1,261		1	1,261	11
12	34	Leasse Expense		1		6,636		1	6,636	12
13	26	Property Insurance		1				1	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 244,885	$		$ 244,885	25

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 67,423	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 65,253	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,170)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 72,082	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 69,912	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	48,854	8
	2000	59,331	9
	2001	58,945	10
	2002	62,573	11
	2003	65,253	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Litchfield HealthCare Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0045753

CONTACT PERSON REGARDING THIS REPORT Chris Henderson

TELEPHONE (832) 467-6307 FAX #: (832) 467-6349

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-100-598-05	PT W 1/2 SW Lands Corp Limits	$ 3,138.62	$ 3,115.26
2.	11-100-598-00	PT W 1/2 SW Lands Corp Limits	$ 62,604.04	$ 62,138.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 65,742.66	$ 65,253.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,189 B. General Construction Type: Exterior Masonary Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Building Inprovement			1982	2,131		20			2,131	10
11	Building Inprovement			1983	2,986		20			2,986	11
12	Building Inprovement			1984	53,393	1,195	20	1,195		53,393	12
13	Building Inprovement			1985	55,378	2,771	20	2,771		54,839	13
14	Building Inprovement			1986	2,920	146	20	146		2,694	14
15	Building Inprovement			1989	5,059	253	20	253		3,751	15
16	Building Inprovement			1990	3,677	184	20	184		2,586	16
17	Building Inprovement			1991	3,100	155	20	155		2,159	17
18	Building Inprovement			1992	10,816	541	20	541		6,818	18
19	See Attached Schedule - Page 12.1			1993	14,559	(3,752)	20	(3,752)		14,559	19
20	See Attached Schedule - Page 12.2			1994	94,548	2,429	20	2,429		25,821	20
21	Windows			1996	599	30	20	30		241	21
22	Rooftop A/C Unit			1996	8,850	443	20	443		3,599	22
23	Painting			1996	5,000	250	20	250		2,142	23
24	Air Conditioner			1997	3,416	171	20	171		1,278	24
25	Fire Alarm System			1997	732	37	20	37		267	25
26	Ground Sign			1997	2,900	145	20	145		1,120	26
27	Paving /Sidewalks Repair			1998	950	63	15	63		438	27
28	HVAC			1998	10,764	538	20	538		3,721	28
29	HVAC - Condensor Replacement Unit			1998	4,275	285	15	285		1,781	29
30	Capet			1998	6,276	610	5	610		6,276	30
31	Landscaping			1998	6,222	622	20	622		4,009	31
32	Handicap Ramp			1998	950	48	20	48		321	32
33	Fire Alarm System			1999	6,809	681	10	681		4,086	33
34	Replc. 2 AO Smith Water			1999	12,500	1,250	10	1,250		7,292	34
35	6: Isandaire A/C Heaters			1999	6,267	1,253	5	1,253		5,677	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Condensor & Coil Rpr W/N Freezer	2000	$ 3,800	$ 253	15	$ 253	$	$ 1,329	37
38	Elec Transfer Switch Instld	2000	2,675	268	10	268		1,429	38
39	F/A Smoke Detection Inspect	2000	782	78	10	78		364	39
40	2: Islandaire Heat/Cool Units	2000	2,168	217	10	217		1,049	40
41	Architect Serv. F/A Systems	2000	16,988	1,699	10	1,699		7,645	41
42	10: 12 BTU HVAC Units	2000	11,038	736	15	736		3,250	42
43	Architect Fees, FA System	2000	8,612	861	10	861		3,731	43
44	Wter Heater - Laundry	2000	5,400	540	10	540		2,250	44
45	Arch Retainage & Reimbursement	2000	5,238	524	10	524		2,183	45
46	Rplc Fire Alarm System App No.1	2000	85,313	8,531	10	8,531		35,546	46
47	Rplc Fire Alarm System App No. 2	2000	45,074	4,507	10	4,507		18,779	47
48	Arch Fee, Reimburse, 11%	2001	3,379	338	10	338		1,380	48
49	Constr fee, Fire alarm, App #3 (2.5%)	2001	3,343	334	10	334		1,365	49
50	7: Islandaire HVAC Units	2001	7,140	476	15	476		1,722	50
51	Use Tax -7 : Islandiare HVAC Units	2001	446	30	15	30		117	51
52	R Concrete, Employee Entrance	2001	1,520	101	15	101		363	52
53	R Concrete, N. Emergency Entrance	2001	1,635	109	15	109		391	53
54	Rprs Roof & Gutters, Pat Rm	2001	3,649	365	10	365		1,216	54
55	Nurse Call System Ungrade	2001	4,350	435	10	435		1,378	55
56									56
57	Service, Nurse Call system	2002	830	83	10	83		263	57
58	Domestic W/H Investigation	2002	2,100	210	10	210		700	58
59	Architect fees - Blue Prints	2002	900	60	15	60		175	59
60	2: Fire Rated Exit Device	2002	6,753	675	10	675		1,744	60
61	Rplc Doors & frames	2002	16,358	1,091	15	1,091		2,817	61
62	Floor Prep Base Tile work	2002	15,246	1,016	15	1,016		2,710	62
63	Plumbing / Kitchen	2002	5,627	281	20	281		750	63
64	Rprs Wall & Door - Kitchen	2002	9,664	644	15	644		1,718	64
65	Electrical Work -Kitchen	2002	1,063	53	20	53		142	65
66	Ext Reclamation / Concrete Patch	2002	2,194	146	15	146		390	66
67	Horns & Strobes Instl - F/A System	2002	2,850	285	10	285		736	67
68	HVAC RTU - 2nd floor Hall N Station	2002	6,695	446	15	446		1,079	68
69									69
70	TOTAL (lines 4 thru 69)		$ 607,906	$ 35,741		$ 35,741	$	$ 312,696	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 607,906	$ 35,741		$ 35,741	$	$ 312,696	1
2	HVAC RTU 1st Floor TV Roon	2002	7,102	473	15	473		1,144	2
3	Architect Fees / Convent Beds	2002	6,230	415	15	415		1,003	3
4	Arch Fee Pat Rm Wardrobes	2002	387	26	15	26		1,059	4
5									5
6	WanderGuard Syst-Intl	2003	688	69	10	69		126	6
7	Rprs WanderGuard Sys	2003	934	93	10	93		179	7
8	2: Door Closer -WanderGuard	2003	1,067	107	10	107		187	8
9	Auto Fire Propection	2003	2,600	260	10	260		433	9
10	WanderGuard Sys Instl	2003	6,651	665	10	665		1,164	10
11	WanderGuard Sys Instl	2003	30,049	3,005	10	3,005		5,509	11
12	Rplc 848: ceiling Tiles	2003	5,168	345	15	345		546	12
13	Arch & Eng Fee Wardr	2003	444	30	15	30		50	13
14	Use Tax Arch & Eng Fee Wardr	2003	30	2	15	2		3	14
15	Replc HVSRTU #4	2003	7,528	502	15	502		753	15
16	Ceiling Mounted Exhaust Fan	2003	5,817	582	10	582		873	16
17	2 Ton Condensing Unit Air Hand	2003	8,047	536	15	536		804	17
18	2: 5Ton A/R Unit Kitchen	2003	16,728	1,673	10	1,673		2,509	18
19	Lumber -Gazebo	2003	791	79	10	79		99	19
20	Rocks, 8Ton Dirt - Gazebo	2003	123	12	10	12		15	20
21									21
22	Double Roof Instl - Gazebo	2004	3,122	338	10	338		338	22
23	6:Heat /Cool Units - Res Rms	2004	5,687	1,043	5	1,043		1,043	23
24	UseTax-6 :Heat/Cool Units - Res	2004	384	70	5	70		70	24
25	Water Cooler, Surface Mount	2004	509	34	10	34		34	25
26	UseTax-Water Cooler, Surface Mt	2004	29	2	10	2		2	26
27	Water Softner Svstem	2004	3,163	79	10	79		79	27
28	Rpr Nurse Call	2004	1,105	18	10	18		18	28
29	2:Heat/Cool Units	2004	1,940	97	10	97		97	29
30	Use Tax-2 :Heat /Cools Units	2004	131	7	10	7		7	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 724,357	$ 46,304		$ 46,304	$	$ 330,840	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 171,127	$ 19,294	$ 19,294	$		$ 111,095	71
72	Current Year Purchases	19,294	1,433	1,433			1,433	72
73	Fully Depreciated Assets	349,248					349,248	73
74								74
75	TOTALS	$ 539,669	$ 20,727	$ 20,727	$		$ 461,776	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,264,027	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 67,031	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 67,031	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 792,616	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 1996	$ 1,166	$ 59	$ 480	86
87	O/H Allocation 1997	2,262	113	833	87
88					88
89					89
90					90
91	TOTALS	$ 3,428	$ 172	$ 1,313	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nationwide Health Properties -(Merger to) Omega Healthcare Partners, L.P. as of Sept 27,1991

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	123	07/01/89	$ 150,000	10	40	3
4	Additions							4
5								5
6								6
7	TOTAL		123		$ 150,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: [X] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning 7/01/89
Ending 6/01/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 12,233 Description: See Attachment pg 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Activities & Errands	2001 Ford XE-350 Super	$ 774.89	$ 9,272	17
18		Van			18
19					19
20					20
21	TOTAL		$ 774.89	$ 9,272	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount		Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Matresses	5602.34		03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102				03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000				03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Diswasher	1,260.00		03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeepin	841000000007040				03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050				03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Adm	841000000008000	Mattress	215.00		03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrativ	841000000008100	Copies, Stamp machine Cable	5,155.92		03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plar	841000000008210				03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220				04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100				03/21/03
			12,233.26		Grand Total

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		1974 hrs	$ 53,057		$	$	1,974	$ 53,057	1
2	Licensed Speech and Language Development Therapist		199 hrs	7,192				199	7,192	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		3902 hrs	108,803			411	3,902	109,214	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				55,900		55,900	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 169,052		$	$ 56,311	6,075	$ 225,363	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,500	$	1
2	Cash-Patient Deposits	29,209		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	348,750		3
4	Supply Inventory (priced at)	12,126		4
5	Short-Term Investments			5
6	Prepaid Insurance	150		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 391,735	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	182,901		15
16	Equipment, at Historical Cost	73,853		16
17	Accumulated Depreciation (book methods)	(51,380)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 205,374	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 597,109	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (51,282)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(143,277)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(3,779)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(69,912)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attachment 17.1	(4,613)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (272,863)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attachment 17.1	261,226		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 261,226	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (11,637)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (585,472)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (597,109)	$	48

***(See instructions.)**

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIIES

	OTHER CURRENT ASSETS:	AMOUNT		OTHER CURRENT LIABILITIES:	AMOUNT	
				Misc Dedctns - Employee <> Other Decductions <> Default	1,908	17 36-1
				Misc Dedctns - Employee <> Union Dues <> Default		
				Accruals - Insurance <> Accrue HMO Ins <> Default		
				Accruals - Insurance <> Self Funded Ins Accr <> Default		
				Accruals - Insurance <> Basic Life <> Default	685	
				Accruals - Insurance <> Lt Dsblty <> Default	314	
				Accruals - Insurance <> Dental Ins <> Default	-	
				Accruals - Insurance <> Executive Supp Life <> Default	206	
				Accruals - Insurance <> Short Term Disability <> Default	-	
				Accruals - Insurance <> Dependent Life <> Default-Dept	87	
				Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	43	
				Accruals - Insurance <> NES Insurance <> Default-Dept	-	
				Accruals - Benefits <> 401k Co Match <> Default	1,371	
	Total	0	Difference	Total	4,614	Difference
	Reconcile with schedule XV, line 9:	0	0	Reconcile with schedule XV, line 36:	4,614	-
	OTHER NON-CURRENT ASSETS:			OTHER NON-CURRENT LIABILITIES::		
	Excess Reorganized Value <>Excess Reorg Value <> Default			Intercompany - Revolver <> Default <> Default	(261,226)	17 43-1
17 23-1	Other Assets <> Rfndable Deposits-Non Int Brg <> Default			N/P - Mortgage <> Mortgages <> Default		
	Total	-	Difference	Total	(261,226)	Difference
	Reconcile with schedule XV, line 23:	0	-	Reconcile with schedule XV, line 43:	(261,226)	0

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 340,176	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 340,176	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	245,297	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 245,297	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 585,473	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,681,196	1
2	Discounts and Allowances for all Levels	(1,635,885)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,045,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	503,698	6
7	Oxygen	14,169	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 517,867	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,570	13
14	Non-Patient Meals	5,366	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	105,925	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	160,808	19
20	Radiology and X-Ray	8,424	20
21	Other Medical Services	40,464	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 333,557	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	General Rental Receipts	100	28
28a	Misc. Receipts	1,451	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,551	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,898,286	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	678,384	31
32	Health Care	1,612,242	32
33	General Administration	953,311	33
	B. Capital Expense		
34	Ownership	255,532	34
	C. Ancillary Expense		
35	Special Cost Centers	85,992	35
36	Provider Participation Fee	67,528	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,652,989	40
41	**Income before Income Taxes (line 30 minus line 40)****	245,297	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 245,297	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SUPPLEMENATAL SCHEDULE OF GENERAL AND MISCELLANEOUS REVENUE

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending Miscellaneous Receipts<>Default<>Prod<>Vending	1,451
Miscellaneous Receipts<>Default<>Prod<>Administrative	100

Total	1,551.00	Difference
Reconcile with schedule XVII, line 28:	1,551	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	-
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-
Miscellaneous Receipts<>Default<>Prod<>Activities	

Total	-	Difference
Reconcile with schedule XVII, line 28a:	0	-

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,273	2,351	$ 76,898	$ 32.71	1
2	Assistant Director of Nursing	2,014	2,083	40,511	19.45	2
3	Registered Nurses	5,733	5,928	107,538	18.14	3
4	Licensed Practical Nurses	19,728	20,400	337,945	16.57	4
5	Nurse Aides & Orderlies	63,693	65,864	646,157	9.81	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	26	26	560	21.54	7
8	Rehab/Therapy Aides	5,969	6,072	169,056	27.84	8
9	Activity Director	2,035	2,084	20,506	9.84	9
10	Activity Assistants	2,297	2,351	15,885	6.76	10
11	Social Service Workers	1,384	1,385	13,651	9.86	11
12	Dietician					12
13	Food Service Supervisor	2,062	2,092	28,531	13.64	13
14	Head Cook	6,723	6,820	61,770	9.06	14
15	Cook Helpers/Assistants	8,639	8,763	60,919	6.95	15
16	Dishwashers					16
17	Maintenance Workers	1,806	1,823	22,157	12.15	17
18	Housekeepers	9,884	10,125	85,076	8.40	18
19	Laundry	7,822	7,906	65,301	8.26	19
20	Administrator	2,051	2,072	66,702	32.19	20
21	Assistant Administrator					21
22	Other Administrative	1,912	1,931	31,461	16.29	22
23	Office Manager					23
24	Clerical	5,021	5,072	81,190	16.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,036	1,100	12,234	11.12	31
32	Other Health Care(specify)	2,104	2,104	41,468	19.71	32
33	Other(specify)	99	115	(872)	-7.58	33
34	TOTAL (lines 1 - 33)	154,311	158,467	$ 1,984,644 *	$ 12.52	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	191	$ 7,632	1-3	35
36	Medical Director	29	9,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	372	19,477	10-7	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,338	11-3	44
45	Social Service Consultant	49	2,668	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	684	$ 41,115		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Mary Buffington	Administrator	100	69,198
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,198

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Legal Fees	Legal Fees	486
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 486

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,655
Unemployment Compensation Insurance	48,547
FICA Taxes	147,867
Employee Health Insurance	102,103
Employee Meals	3,710
Illinois Municipal Retirement Fund (IMRF)*	
Pension / Retirement	1,357
Insurance Life	2,726
Other Benefits	1,641
Less Meals Not Allowed	(3,710)
TOTAL (agree to Schedule V, line 22, col.8)	$ 397,896

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,395
Health Care Worker Background Check	
(Indicate # of checks performed)	662
Other License Fees	2,459
Dues	6,176
Home Office Allocation	803
Total Advertising	7,111
Less: Public Relations Expense	(100)
Non-allowable advertising	(4,734)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,772

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,050
In-State Travel	9,241
Home Office Allocation	10,001
Seminar Expense	2,344
Entertainment Expense	(2)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,634

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn -$ 5,904**

(3) Did the nursing home make political contributions or payments to a political action organization? **Nn** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,795** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? _____ If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67,528**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,710** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,710**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.